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Safety & Recovery

Environmental factors that promote safety and recovery
To advance recovery it is necessary to understand what helps individuals decide to find and undertake their particular recovery path. Clinical and architectural programming can either help or hinder this process. There are multiple factors to consider when balancing safety and recovery. In keeping with this approach it is useful to examine what environmental factors promote safety and foster recovery.

What helps to create an environment of safety?

- Therapeutic response to violence – learning, healing
- Consumer council
- Spirit of inquiry
- Emotional intelligence
- Interpreting behavior accurately
- Active treatment of physical and psychiatric symptoms
- Space
    - Low crowding
    - Private space
    - Calming space (comfort room)
    - Room to move
- Flexibility in rules
- Community rules, norms, expectations – client driven
- Consistency
- Shared vigilance and responsibility for safety
- Safety plans/agreements
    - Realistic and supported with resources
- Supervision, training and support for staff
    - Trauma
    - Support following events
    - Self-care plans
- Differentiating between violence and other disruptive behavior
- Focus on strengths, success
- Responding to positives
- Shared respect

Strategies to Promote Safety
Planning for safety involves both systemic and individualized strategies. One key component of service systems that are successful in promoting a sense of safety (by finding alternative ways to deal with tension and conflict is the use of daily community meetings. These should be run and participated in by both residents and clinical staff. Community meetings should routinely explore feelings related to potential for aggression and shared responsibility for maintaining a safe environment. They should also explicitly address acts of aggression as they occur. The over-all ethic of the program is the creation

of a learning environment designed to maximize individual recovery through an on-going process of exploration and analysis to identify what program processes are effective and applicable to all residents, as well as what works best for particular individuals.

The availability of multiple strategies for crisis management and diversion is essential to crisis prevention. These include:

- Sensory – shower, sensory room or kit, calming room, music, tactile stimulation
- Interpersonal – telephone, conversation with staff, peers
- Spiritual comfort – (e.g., access to green space, meditation, etc.)
- Physical – gross motor (e.g., gym) or fine motor (e.g., ripping paper)
- Privacy – having a quiet space of one's own

In addition to systemic strategies such as those mentioned above, planning should be conducted with each individual to support prevention of involuntary emergency procedures and to assist individuals and clinical staff to navigate potential crisis situations. A safety and support agreement should be completed with each individual at admission and should be reviewed and revised as needed at each treatment and recovery planning session and whenever circumstances indicate a need to do so (for example, should an episode of aggression, self-harm, seclusion, restraint, or involuntary medication occur).

Crisis Intervention

The management of the risk of aggression and maintenance of safe environment are a given state of the program and will be a consideration in all aspects of program development. An awareness of what situations foster aggression and what can help to support an environment of safety will be a topic of initial and annual staff training and ongoing dialogue.

What fosters aggression?

- Fear/feeling cornered
- Too much staff/environmental control
- Rules and regulations which are inflexibly applied
- Implementation of rules around smoking
- Too many walls – not enough open space
- Disrespect
- Active symptoms of mental illness left untreated
- Staff feeling afraid/devalued
- Aggression from others
- Low tolerance for things going wrong
- Low tolerance for disruptive behavior/intense emotion
- Lack of staff support/training to manage fear/emotion
- Gaining attention
- Staff avoidance
- Rushing to intervene

- Past negative experience with seclusion/restraint

Seclusion and Restraint are Not Program Strategies
Seclusion or restraint will not be employed as treatment interventions and will be considered methods of last resort for limiting harm to individuals and staff. To support a coercion-free environment, the program will have as a primary objective the attainment of zero use of restraint and seclusion. Should an incident involving seclusion and restraint occur it will be treated as a major sentinel event requiring intensive and extensive analyses and action by staff at all levels to prevent repetition.

To ensure systemic planning to support this policy, the Six Core Strategies for reducing use of seclusion and restraint identified by the National Association of State Mental Health Program Directors will be implemented at start-up in the SRR. Annual evaluation of success in implementing the six core strategies and in preventing and managing crises will support ongoing improvements in this area.

Six Core Strategies for Reduction of Seclusion and Restraint
National Association of State Mental Health Program Directors (NASMHPD)

1. **Leadership toward Organizational Change**
   - Value Statement
   - Policies
   - Action Plans
   - Monitoring S/R Trends
   - Creating recognition opportunities for staff successes

2. **Use of Data to Inform Practice**
   - Describe trends in Action to support success or suggest further improvements
   - Understandable and available

3. **Workforce Development**
   - Staff Training
   - Development of recovery-oriented treatment environments

4. **Use of S/R Prevention Tools**
   - Risk/history/trauma assessments
   - Crisis/safety plans
   - Person-first language
   - Beneficial environmental change
   - Use of sensory and therpeutic interventions to develop self regulatory behavior

5. **Consumer Roles in Inpatient Settings**
   - Event oversight
   - Peer support services

- Roles on key facility committees
- Employment
- Consumers, families, and advocates

6. Debriefing Techniques

- Non-blaming, rigorous analysis
- Knowledge to improve care
- Informal (post-incident check-in) and formal (Root Cause Analysis)